

2/8/10 emailed Validation letter  
LTC Access ✓

**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only  
Received 2/3/10  
Amount 1365.00

A 7318

**I. IDENTIFICATION**

Name St. Charles Care Center, Inc.

Address 500 Farrell Drive

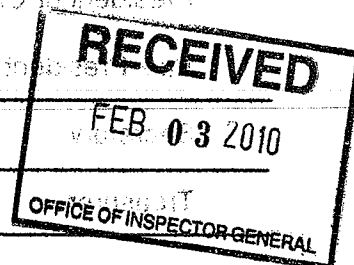
City/County/Zip Covington / Kenton / 41011

Telephone number 859-331-3224 smluann@zoomtown.com

Administrator Sr. Mary Luann Bender

Date facility operation began at current address March 19, 1961

Date facility began operation under current owner March 19, 1961



**II. TYPE BEDS**

No. beds licensed

No. beds requested

Skilled

Nursing Home

Nursing Facility

91

Intermediate Care

ICF/MR

Personal Care

**II. CONTROL (check one in each column)**

State  
County  
City  
Private

Profit  
Nonprofit **X**

Individual  
Partnership  
Corporation **X**

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

St. Charles Care Center, Inc.

500 Farrell Drive  
Covington, KY 41011

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation St. Charles Care Center, Inc.

Address of corporation 500 Farrell Drive, Covington, KY 41011

President or Chairman Sr. Mary Luann Bender

Vice President NA

Secretary Rita Watkins

Treasurer Nancy J. Campbell

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent

Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Sr. Mary Luann Bender  
Signature of authorized representative

President 2/01/2010  
Title Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)